STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011437	A. BUILDING: _____ B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Complaint Number: IN00113008 Unsubstantiated; lack of sufficient evidence Facility Number: 011437 Survey Date: 05/07/13 Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor Community Hospital North is in compliance with 410 IAC 15-1.6.5, Psychiatric services, Hospital Licensure Rules. QA: claughlin 07/15/13	S 000		